STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	10/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00116929. Complaint IN00116929: Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F282, F309. Survey dates: October 2, 3, 2012 Facility number: 000459 Provider number: 155567 AIM number: 100289700 Survey team: Ann Armey, RN Census bed type: SNF: 3 SNF/NF: 73 Total: 76 Census payor type: Medicare: 3 Medicaid: 51 Other: 22 Total: 76 Sample: 4 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	10/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality review completed on October 4, 2012 by Bev Faulkner, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	10/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, interview and record review, the facility failed to notify the physician when a medication was repeatedly held due to low blood pressures. This deficiency affected 1 of 4	F0157	It is the practice of University Park to notify the resident's physician, resident, their legal representative and interested family members of an accident, change in condition or room	10/15/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	10/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	residents, whose medications were reviewed, in a sample of 4. (Resident #D) Findings include: On 10/2/12 at 9:10 a.m., during the orientation tour, accompanied by the DON (Director of Nursing), Resident #D was observed lying in bed. The resident had ace wraps on her lower legs. The DON indicated the resident had congestive heart failure, chronic edema and was receiving hospice care. The clinical record of Resident #D was reviewed on 10/2/12 at 2:30 p.m. and indicated the resident was admitted to the facility on 1/12/12, with diagnoses which included but were not limited to, diastolic heart failure, chronic pulmonary heart disease, and hypertension. The September 2012 MAR (Medication Administration Record) indicated Resident #D was to receive Lisinopril (a medication used to treat hypertension and heart failure) 20 mg every day. The order further indicated the Lisinopril was to be held if the systolic blood pressure was less than 100 and the diastolic blood pressure less than 60. The Lisinopril was held on 16 occasions in September due to blood pressure		move.a.) The nurse practitioner was notified. Resident D's blood pressure medication was discontinued. no other residents were affected.b.) All other residents with blood pressure medications that requried B/P parameters have been audited by the DON/unit managers/designee. No other residents were affected. all resients in the facility had the potential to be affected. were reviewed for compliance. (See attachment #1)c.) The 3 staff nurses involved received disciplinary action forms for their record, (see attachment #2 of forms) and medication error sheets were done for each nurse. (see attachment #3)A re-education was conducted by the DON/.DSD on proper reporting procedure of resident change of condition. (see attachment #4 content of education and SBAR)d.) The unit managers will use a drug parameter audit tool to track and insure compliance. Audits will be conducted weekly x's 4 weeks, by DON/Unit managers/Designee, then monthly thereafter x 6 months, Unit Managers or designee will be responsible, To bring the audit tools to the monthly QA committee meetings for compliance review, for 6 months or until 100% compliance on the audit tools is this will be reviewed by QA committee and will be ongoing..Date of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	10/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	readings that were below the designated parameters, as follows: on 9/3/12, due to a blood pressure of 88/44; on 9/4/12, due to a blood pressure of 90/50; on 9/5/12, due to a blood pressure of 88/44; on 9/6/12, due to a blood pressure of 99/55; on 9/7/12, due to a blood pressure of 111/57; on 9/10/12, due to a blood pressure of 99/64; on 9/11/12, due to a blood pressure of 92/45; on 9/13/12, due to a blood pressure of 106/54; on 9/17/12, due to a blood pressure of 124/55; on 9/18/12, due to a blood pressure of 113/55; on 9/19/12, due to a blood pressure of 99/54; on 9/20/12, due to a blood pressure of 98/56; on 9/21/12, due to a blood pressure of 95/60; on 9/24/12, due to a blood pressure of 87/69; on 9/25/12, due to a blood pressure of 92/54; on 9/26/12, due to a blood pressure of 106/55;		completion: 10/15/12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	10/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Although the medication was repeatedly held because the resident's blood pressure fell below the designated parameter, there was no documentation the physician was notified until 10/2/12. On 10/2/12, Nurse Practitioner notes indicated Resident #D's Lisinopril would be discontinued "due to chronically low B/P (Blood Pressures)...." On 10/3/12 at 10:00 a.m., the DON indicated she could not find any documentation the physician had been consulted or notified about Resident #D's Lisinopril being repeatedly held prior to 10/2/12. She indicated the facility did not have a specific policy about notifying the physician when medications were held. This Federal tag relates to Complaint IN00116929. 3.1-5(a)(3)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	10/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to follow physician orders to hold a medication. This deficiency affected 1 of 4 residents, whose medications were reviewed, in a sample of 4. (Resident #D) Findings include: On 10/2/12 at 9:10 a.m., during the orientation tour, accompanied by the DON (Director of Nursing), Resident #D was observed lying in bed. The resident had ace wraps on her lower legs. The DON indicated the resident had congestive heart failure, chronic edema and was receiving hospice care. The clinical record of Resident #D was reviewed on 10/2/12 at 2:30 p.m., and indicated the resident was admitted to the facility on 1/12/12, with diagnoses which included but were not limited to, diastolic heart failure, chronic pulmonary heart disease, and hypertension. The September 2012 MAR (Medication	F0282	a.) The nurse practitioner was notified. Resident B/P pressure medication was discontinued no other residents were affected.b.) All other residents that had the potential to be affected have been audited by the DON/unit managers/designee. (see attached unit audit tools#1) There were no other residents found affected..c.) The 3 Nurses involved were disciplined and the discipline forms attached to their record.(See attachments # 2&3) Medication error sheets were done. A re-education was done on the proper procedure by the DON/DSD (See attachment #4)for the Nurses involved.d.) The unit managers or designee will implement use of drug parameter audit tool, (See Attachments #1) audits will be conducted weekly x's4 weeks and then month x's 6 months. Unit Managers or Designee will bring audits to the monthly QA committee meetings for comliance review, for 6 months or until 100% compliance is achieved.. Date of Completion: 10/15/12	10/15/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	10/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Administration Record) indicated Resident #D was to receive Lisinopril (a medication used to treat hypertension and heart failure) 20 mg every day. The order further indicated the Lisinopril was to be held if the systolic blood pressure was less than 100 and the diastolic blood pressure less than 60. The MAR indicated the Lisinopril was administered on six occasions, when it should have been held. For example, the Lisinopril was administered to Resident #D on 9/8/12 at 9:00 a.m., when her blood pressure was 86/44; 9/9/12 at 9:00 a.m., when her blood pressure was 82/45; 9/12/12 at 9:00 a.m., when her blood pressure was 90/56; 9/16/12 at 9:00 a.m., when her blood pressure was 93/78; 9/22/12 at 9:00 a.m., when her blood pressure was 104/54; and 9/27/12 at 9:00 a.m., when her blood pressure was 98/66. On 10/3/12 at 10:00 a.m., the DON indicated the Lisinopril should have been held when the resident's blood pressure fell below the parameters designated by the physician. She indicated the Nurse Practitioner was notified about Resident #D's low blood pressures and the Lisinopril was discontinued on 10/2/12.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	10/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The DON indicated the physician and family were notified regarding the medication errors on 10/3/12. This Federal tag relates to Complaint IN00116929. 3.1-35(g)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	10/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to assess a resident following a change in condition. This deficiency affected 1 of 3 residents reviewed with condition changes in a sample of 4 residents. (Resident #B) Findings include: The closed clinical record of Resident #B was reviewed on 10/2/12 at 11:00 a.m., and indicated the resident was admitted to the facility on 10/24/07, with diagnoses which included but were not limited to, congestive heart failure, diabetes mellitus and chronic obstructive pulmonary disease. Resident #B was transferred to the hospital on 9/15/12 and was subsequently discharged from the	F0309	It is the practice of University Park to provide the necessary care and services to attain and maintain the highest practicable physical, mental, and psychosocial well-being. a.) Resident B discharged from our facility on 9/15/12b.) No other residents were affected.c.) Nursing staff were re-educated, documentation and assessment as it pertatins to change of condition (SBAR)see attachment #4 (see attachment #5&6) for content.d. The post SBAR/Change of condition documentation sheet will be used daily for documentation for the next 4 weeks 5x's weekly, then weekly for 6 months the DON/Unit managers/designee will monitor weekly 6 months, completion of post SBAR form. This will be brought to the monthly QA meetings for review by the QA committee, x's 6 months.Or until 100% compliance is achievedDate of Completion: 10/15/12	10/15/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	10/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility. On 9/14/12 at 2:00 p.m., a Change of Condition (SBAR) Assessment indicated Resident #B had an increase in edema. The assessment indicated the resident had 3+ pitting edema of the right and left lower extremities with seeping, which started on 9/14/12. The resident's vital signs were checked and the resident's temperature was noted to be 98.3 degrees The Nurse Practitioner was notified and the resident's Lasix was increased to 40 mg twice daily. The Change of Condition Assessment indicated the resident's vital signs and clinical condition was to be assessed for 72 hours. On 9/15/12 at 1:25 a.m., nursing notes indicated "edema continues BLE (Bilateral Lower Extremities). Encourage resident to keep feet (up symbol) on pillows." There was no documentation that the resident's vital sign, lung sounds or the condition of the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	10/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	lower extremities were assessed during the night shift. On 9/15/12 at 9:30 a.m., (19 hours after the initial assessment) nursing notes indicated Resident #B had pitting edema to her bilateral lower extremities from thighs to feet and rhonchi in her lower lobes. The resident's vital signs were 122/67, pulse 50, respirations 20, temperature 96.7, with an oxygen saturation rate of 93%. The nurse practitioner was notified and the resident was transported to the hospital at the request of the family at 10:00 a.m. There was no documentation the resident's lower extremities were assessed prior to the resident's transport to the hospital. The Hospital Emergency Department report, dated 9/15/12 at 11:10 a.m., indicated the resident had multiple open areas on her lower extremities that were seeping serosanguinous fluid.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	10/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The hospital history and physical, dated 9/15/12, indicated "...There is extensive erythematous changes in both legs with desquamation of the skin in both feet. On the right leg anteriorly, there are areas of purulent discharge and also serosanguineous discharge with skin breakdown in some parts..." The report indicated the resident had a diagnoses of "Cellulitis to both lower extremities with areas of infection" and "Decompensated congestive heart failure." On 10/2/12 at 3:15 p.m. ,and 10/3/12 at 11:25 a.m., LPN #10, who worked on the night shift, on 9/15/12, was interviewed. LPN #10 indicated she took the resident's vitals and wrote them in her notebook, but did not document them in the clinical record. She indicated she wrapped Resident #B's lower legs with ace bandages on 9/15/12 around 6:00 a.m., and the resident had small round red sores/indentations on her			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING _____ B. WING 00	10/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	lower leg, but she did not notice any drainage. LPN #10 indicated she did not document the location, size or description of the areas on the resident's legs. On 10/2/12 at 3:45 p.m., RN #11, who was on duty when the resident was transported the hospital, was interviewed. RN #11 indicated the resident's daughter called and wanted her mother transported to the hospital. She indicated when she checked the resident's lung sounds they were wet and she notified the Nurse Practitioner. RN #11 indicated she did not remove Resident #B's ace wraps to assess the resident's lower legs before she was transported to the hospital. On 10/3/12 at 10:30 a.m., the DON (Director of Nursing) was interviewed. The DON indicated there was no specific policy regarding assessments following a change of condition. The DON indicated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	10/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	when a resident had a change of condition the nurses were to complete a change of condition assessment, then complete follow-up assessments of the resident's condition and document the assessment every shift for 72 hours hours. This Federal tag relates to Complaint IN00116929. 3.1-37(a)			